

VERIFICATION OF PROFESSIONAL EMPLOYMENT

1. If you are currently practicing, please have the **facility** where you actually practice complete this form and return it to this office.
2. If you are not currently practicing, please have the **facility** where you most recently practiced complete this form and return it to our office.

PLEASE BE AWARE THAT THIS FORM MUST BE COMPLETED BY THE FACILITY WHERE YOU ACTUALLY PRACTICE, NOT A CONTRACTING OR PLACEMENT AGENCY.

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO YOUR EMPLOYER

DEAR CURRENT OR MOST RECENT PROFESSIONAL EMPLOYER:

In applying for a license to practice _____ in South Dakota, the Medical Board requires this form to be completed by my current, or most recent, professional employer. This is your authority to release any information in your files, favorable or otherwise, direct to:

South Dakota State Board of
Medical & Osteopathic Examiners
125 S. Main Ave.
Sioux Falls, SD 57104

(Signature)

Name: _____

Address: _____

DO NOT DETACH

Name of Current or Most Recent Professional Employer: _____

Address of Current or Most Recent Professional Employer: _____

Name of Current or Former Employee: _____

If former, was employee's employment terminated? _____ (Yes or No)

If YES, Why? _____

Derogatory Information, if any: _____

Comments, if any: _____

Signed: _____

Title: _____

Date: _____